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Medicaid Expenditures and Coverage

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. Although North Carolina has experienced significant increases in Medicaid program expenditures in recent years, much of this change can be attributed to increases in the number of Medicaid eligibles.	▪ North Carolina should develop more creative strategies for controlling Medicaid expenditures and should only eliminate eligible groups and optional services, or impose restrictive service limits, as options of last resort.	▪ Controlling Medicaid expenditures may produce the desired outcome without adversely affecting recipients or providers.	1.13
2. In general, the Division of Medical Assistance has accurately projected the State Medicaid budget.	▪ The Medicaid budget projection methodology should be enhanced by building a consensus among agency and legislative staff.	▪ Improves the accuracy of budget projections. ▪ Enables agencies to make adjustments. ▪ Encourages agencies and legislative staff to work together.	1.16
3. North Carolina does not require a copayment by Medicaid recipients for inpatient hospital and other services, for which copayments may be applied.	▪ Impose copayments for inpatient hospital and other services for Medicaid recipients.	▪ Reduces the cost to the State for inpatient hospital care and other services by $5.3 million.	1.17

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
4. While much of the growth in the North Carolina Medicaid Program can be attributed to the increase in eligibles mandated by federal law, reimbursement methodologies can be structured to more aggressively limit rates of increase in expenditures, as well as the overall level of expenditures.	▪ Program-specific recommendations are made in subsequent issue papers.	▪ Program-specific results are discussed in subsequent issue papers.	1.18

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Medicaid Reimbursement of Inpatient Hospital Services

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. North Carolina Medicaid expenditures for inpatient hospital services are comparable to other states; however, average length of stay is among the highest in the country. 2. While North Carolina's reimbursement system exerts some cost control, other systems more effectively control costs and encourage appropriate utilization. 3. North Carolina's reimbursement system has controlled payments for capital-related costs and medical education costs.	▪ The Division of Medical Assistance should implement a DRG-based reimbursement system which uses peer groups to establish base payment amounts.	▪ Cumulative savings of $70.4 million would occur over a 10-year period. ▪ Reimbursement on the basis of discharge controls the average length of stay. ▪ Encourages appropriate utilization of hospital services. ▪ Provides incentives to operate efficiently.	2.21

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
4. North Carolina does not negotiate with providers to obtain better rates in areas of the State where competition among hospitals exists.	▪ The Division of Medical Assistance should implement selective contracting programs in geographically feasible regions of the State.	▪ Cumulative savings of $118.6 million would occur over a 10-year period. ▪ Encourages the utilization of low-cost facilities. ▪ Provides an incentive to operate efficiently, and compete on the basis of costs.	2.23
5. Overall costs per inpatient stay in North Carolina hospitals are high in comparison to other southeastern states.	▪ The General Assembly should develop a global budgeting approach to hospital reimbursement for all payers on a pilot basis in one area of the State.	▪ Develops a methodology that allows budget determination to be made for each facility that is related to the function of the facility. ▪ Limits the total level of reimbursement for services to a particular entity. ▪ Cost reductions are significant depending upon areas in which the pilot would be implemented.	2.23

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Medicaid Reimbursement of Outpatient Hospital Services

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. Cost-based reimbursement has been ineffective in controlling outpatient hospital expenditures. 2. North Carolina Medicaid outpatient hospital reimbursement policy does not provide comparable payment across providers for comparable care. 3. Reporting on hospital outpatient claims is insufficient to determine exactly what kinds of services are being provided.	▪ The Division of Medical Assistance should move away from a cost-based payment approach for outpatient hospital services to a bundled, prospective payment approach.	▪ Encourages hospitals to control costs and efficiently use resources. ▪ Avoids the problem of billing fragmentation. ▪ Cumulative savings over a 10-year period would be $12 million.	3.8

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Medicaid Reimbursement of Nursing Facility Services

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. The North Carolina reimbursement methodology provides more generous reimbursement for certain cost components in comparison to other states.	▪ The Division of Medical Assistance should eliminate return on equity payments. ▪ The Division of Medical Assistance should establish a cap on indirect care efficiency payments. ▪ The Division of Medical Assistance should implement a prospective, peer-grouped, case mix-based reimbursement methodology.	▪ Reduces Medicaid expenditures by $16.2 million over a 10-year period. ▪ Reduces Medicaid expenditures by $31.4 million over a 10-year period. ▪ Saves approximately $112.6 million over a 10-year period. ▪ Identifies facilities that can be expected to incur similar costs based on certain statistically valid variables such as geographic location, bed size, and occupancy levels. ▪ Promotes access to patients requiring higher levels of care.	4.12

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Physician Services Provided Under Medicaid

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. North Carolina Medicaid expenditures for physician services are above the national average. 2. Access to primary care for Medicaid patients is limited in certain areas of the State. 3. Carolina Access has produced significant savings across Medicaid program areas.	▪ The Division of Medical Assistance should implement Carolina Access on a statewide basis. ▪ The Division of Medical Assistance should expand the use of managed care options.	▪ Cost savings for moving Carolina Access forward would net $23.2 million over the next 10 years. ▪ Physicians are given greater incentives to monitor and control utilization. ▪ Medicaid expenditures across several program areas (e.g., prescription drugs, inpatient and outpatient hospital services) can be reduced.	5.10

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Medicaid Reimbursement for Prescription Drugs

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. North Carolina Medicaid expenditures per prescription are higher than in other states. 2. The North Carolina Medicaid dispensing fee is the highest in the country. 3. North Carolina Medicaid has implemented other cost containment strategies, including a six prescription limit per month and a copayment amount of $1.00 per prescription.	▪ The Division of Medical Assistance should implement alternative purchasing approaches for prescription drugs. ▪ The General Assembly should freeze the dispensing fee at the current amount.	▪ Initial cost savings for the first year of implementation would net $5.7 million. Cumulative savings to the prescription drug program would total $102.1 million over 10 years. ▪ Achieves cost savings without major disruption to community providers. ▪ Through the establishment of networks, Medicaid recipients may have greater access to other managed care interventions, such as on-line drug utilization review and patient-and drug-specific exclusions.	6.8

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Health Care for the Developmentally Disabled and Mentally Retarded

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. Intermediate care facilities for the mentally retarded (ICFs/MR) continue to be developed in North Carolina, even though most states have decreased the number of individuals residing in ICFs/MR.	▪ The General Assembly should limit the growth in the number of intermediate care facilities for persons with mental retardation by implementing a moratorium on the development of new ICF/MR beds. ▪ Transition inappropriately placed ICF/MR residents to home and community-based services.	▪ The first-year savings are $2.4 million with a cumulative savings of $135.1 million over the next 10 years. ▪ Provides services in a more appropriate setting.	7.9
2. North Carolina rates for private ICFs/MR are ranked among the highest in the country.	▪ The Division of Medical Assistance should develop a prospective, case-mix methodology for ICF/MR reimbursement.	▪ The initial year's cost savings for the State would be $1.4 million with a cumulative savings of $19.5 over the next 10 years.	7.9

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Certificate of Need

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. The Certificate of Need (CON) process has not been effective in controlling the development and expansion of hospital beds and purchase of high technology equipment in North Carolina. 2. North Carolina's current methodology for projecting need for additional long-term care facilities' beds can be improved.	▪ The General Assembly should change the current bed need formula by expanding the size of current health planning areas to include larger geographic regions and including alternative (non-institutional) services. ▪ The General Assembly should implement a moratorium on developing ICF/MR beds. ▪ CON should continue for long-term care beds; reimbursement system changes should be used to promote savings.	▪ Provides more accurate projection of bed need. ▪ Savings on the first-year moratorium would be approximately $2.4 million. Cumulative savings if the moratorium were extended for 10 years would be $113 million. ▪ Ensures appropriate placement and utilization of community-based services.	8.12
3. North Carolina does not require a CON for major medical equipment purchases.	▪ The General Assembly should decrease the capital threshold to $500,000 for projects requiring CON approval.	▪ A decrease in the capital threshold to $500,000 will put North Carolina more in line with other states' thresholds for major medical equipment.	8.14
4. Application fees collected by the CON program do not cover the cost of this program.	▪ The CON program should be self-funded.	▪ If the CON program were self-funded, additional revenue from application fees would total $200,000.	8.15

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Managed Care Strategies for the North Carolina Medicaid Program

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. North Carolina lags behind other states in its development of managed care programs.	▪ The Division of Medical Assistance should expand Carolina Access statewide and introduce elements of risk-sharing.	▪ More appealing to physicians who are generally adverse to risk.	9.9
2. Carolina Access is a positive step toward managed care.	▪ Develop a statewide managed care program by contracting with existing provider networks.	▪ Based on other states' experiences, North Carolina would experience an initial expenditure of $800,000 in the first year of implementation. However, by year 3, actual State savings would be approximately $47.9 million. Estimated savings over the 10-year period would be $2.5 billion.	9.10
3. Managed care programs offer several advantages over traditional fee-for-service arrangements.	▪ Evaluate the feasibility of statewide managed care programs for certain populations and certain regions of the State.	▪ Provides guidance as managed care options are developed and evaluated.	9.11

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State Purchase of Health Care

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
1. Existing information systems are ill-prepared to support cost-containment efforts.	▪ The General Assembly should establish an office for health care within the Governor's Office and empower the office as the central agent for coordination and design of the North Carolina health care strategy.	▪ Savings accruing from additional administrative activities will offset costs within the first full year of operation.	10.18
2. Post-payment claims databases and consolidated reporting are limited or nonexistent within most agencies; cross-program sharing of post-payment data is nonexistent.	▪ The General Assembly should consolidate the administration of State employee workers' compensation claims and reform the funding approach.	▪ Administrative consolidation could reduce personnel requirements by 10 positions and create savings from uniform application of policy. ▪ First-year cost savings total approximately $1.1 million. Cost savings over 10 years total $13.9 million.	10.18
3. The Medicaid Management Information System (MMIS), which is contracted by the Division of Medical Assistance, is the most sophisticated of the State's claims systems and is a candidate for replacement.	▪ Initiate planning for the replacement of the current MMIS.	▪ Provides North Carolina with an opportunity to define and promote a strategy consistent with State political and social objectives.	10.18

FINDINGS	RECOMMENDATIONS	RESULTS	REPORT PAGE
4. Development of claims processing systems appears to be more short-term than long-term in its approach.			10.13
5. Most programs practice good utilization control through prior authorization, but in some programs utilization control is nonexistent.			10.14
6. Most programs, with the exception of contracted services, adhere to the Medicaid fee schedule for most services.			10.14
7. Current combined purchasing efforts appear to be effective.			10.14